Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 07/21/01 through 03/07/02.
   b. The request was received on 07/03/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFAs-1500
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The Commission requested two copies of additional documentation via a Fee Letter (MR116) that was mailed to the Requestor on 07/30/02 in accordance with Rule 133.307 (g) (3). The provider did not respond. Therefore, the Commission could not forward any additional documentation to the carrier per rule 133.307 (g) (4). The case file does not contain a carrier sign sheet. The carrier did submit an initial response dated 07/11/02. All information in the case file will be reviewed and considered timely.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 06/28/02
   "(Provider) is requesting a hearing before the Medical Review Division because (Carrier) has improperly reduced or denied payment for services rendered to (Claimant)….(Carrier) reduced payment incorrectly for CPT code 97750-FC. According to TWCC fee guidelines page 35 it is to be reimbursed for $100 per hour for a maximum of five hours. (Carrier) also did not pay our usual and customary charge for CPT code 64999. (Provider) did supply the carrier with EOB's from other carriers that pay his usual and customary for this particular charge."

2. Respondent: No position statement

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 07/21/01 through 03/07/02.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. Per the provider's TWCC-60, the amount billed is $1,034.00; the amount paid is $560.80; the amount in dispute is $473.20.

3. The carrier denied the billed services by codes:
"T033 THE TESTING PROVIDED IS INVESTIGATIVE AND IS NOT COVERED UNDER WORKERS COMPENSATION.";
"PAY F – THIS PROCEDURE CODE IS REIMBURSED BASED ON THE MEDICAL FEE GUIDELINE. IF A FEE SCHEDULE IS NOT MANDATED, THE UCR ALLOWANCE IS REIMBURSED FOR THE ZIP CODE AREA.";
"DOP – M – REIMBURSED PER THE INSURANCE CARRIERS FAIR AND REASONABLE ALLOWANCE."

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
07/21/01	64999	$248.00	$198.40	T033	DOP	133.307 (g) (3) (B) CPT descriptor	There is no medical documentation submitted for the date of service to support that the medical services were rendered by the Requestor. The service was billed by and performed by another doctor. **No** reimbursement is recommended.
10/08/01	97750-FC	$290.00	$43.00	PAY F	$100.00 per hour	MFG MGR (I) (E) (2); CPT descriptor	According to the MFG, a FCE shall include a summary report for each FCE. The provider failed to submit the required summaries of a physical exam and a neurological evaluation. **No** reimbursement is recommended.
12/07/01	64999	$248.00	$121.00	M	DOP	Rule 133.307 (g) (3) (D); CPT descriptor	As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. The evidence submitted by the provider proved to be insufficient to meet the criteria of Rule 133.307 (g) (3) (D). Out of the seven EOBs submitted by the provider as evidence of fair and reasonable, one was for another doctor; three had no ICD-9 codes; one was for a cervical area; and two were for the lumbar area. **No** reimbursement is recommended.
03/07/02	64999	$248.00	$198.40	M	DOP	Rule 133.307 (g) (3) (B); CPT descriptor	There is no medical documentation submitted for the date of service to support that the medical services were rendered by the Requestor. The service was billed by and performed by another doctor. **No** reimbursement is recommended.
Totals		$1,034.00	$560.80				The Requestor **is not** entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 3rd day of February 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm